RILEY COUNTY Health Department

Riley County Health Department
2030 Tecumseh Rd
Manhattan, Kansas 66502
Phone: 785-776-4779
Fax: 785-565-6566
www.rileycountyks.gov/health

2016-2017 Influenza Consent Form

PATIENT INFORMATION

Date:	Patient's First Name:	Middle Name:	Last Name:	Maiden Name/Alias:

Birth Date:	Age:	Social Security Number:	Primary Language:	Doctor:

Ethnicity: Hispanic ____Yes ____No

Gender ____Male ____Female

Race:
____Asian/Pacific Islander/Other
____Black or African American
____Caucasian or White
____Hawaiian
____Native American/Alaska Native
____Unknown or Other _____

Mailing Address:	City:	State:	County:	Zip Code:

Phone Number:	Email Address:

INSURANCE INFORMATION

Please fill out the following information completely AND submit a copy of your insurance card.

PRIMARY INSURANCE

Policy Holder Name _____ Birthdate_____
Patient relationship to policy holder: Self Spouse Child Other_____
ID#_____Group #_____

SECONDARY INSURANCE

Policy Holder Name _____ Birthdate_____
Patient relationship to policy holder: Self Spouse Child Other_____
ID#_____Group #_____

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Are you sick or experiencing a high fever?	Yes No
2. Do you have allergies to medications, food, a vaccine component, or latex? List:	Yes No
3. Have you ever had a serious reaction after receiving a vaccination? Please explain:	Yes No
4. Have you ever had Guillain-Barré syndrome? (autoimmune disorder in which the immune system attacks nerve cells)	Yes No
5. **For those 65 years of age and older:** I have received the Pneumococcal vaccines, both PPSV23 and Prevnar 13?	Yes No Unknown

VACCINE CONSENT

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

☐**Influenza** ☐**Prevnar 13** ☐**PPSV23** ☐**Tdap** ☐**Other**

X_____ **Date:**_____

Signature of Client or Parent/Guardian

PATIENT ELIGIBILITY (FOR CLINIC AND/OR OFFICE USE ONLY)

	T19-MED	**Manufacturer:**	**90662**	FLU HIGH DOSE
	No Health Insurance ≤ 18	**Lot Number:**	**90688**	FLU-MDV
	Nat Am/Al Nat	**Expiration Date:**	**90687**	FLU-MDV-Infant
	Underinsured	**INJECTION SITE:**	**90686** P/T21/T19	FLU PF > 36 Mths
	T21-CHIP	**Left / Right** **Deltoid / Vastus Lateralus**	**90686V**	FLU PF > 36 Mths VFC
	Fully Insured		**90685** P/T21/T19	FLU PF 6-35 Mths
	No health insurance ≥ 19		**90685V**	FLU PF 6-35 Mths VFC
		_____	**90471**	1st Injection
	FREE FLU – NO CHARGE	**VACCINE ADMINISTRATOR:** **Date:**		